

PASSPORT To Health Summit
Billings
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Examine the four objectives of the PASSPORT Program

1. Foster a medical home between provider and clients

- a. **How is PASSPORT successful in meeting this objective? What do you appreciate about it? What currently works smoothly?**
- It's a really good theory; we don't deny care.
 - The well child visits, letters that go out, and patients that show up.
 - It's the best insurance claims for kids with special needs. The patients are very appreciative of this.
 - If we can educate the patient... People who receive it need to be informed to go to their PCP when they need a referral. Explain "These are your responsibilities..."
 - IHS does a good job of explaining they are the medical home providers.
- b. **What doesn't work as well as you need or want it to? What problems do you experience? What concerns do you have about this objective?**
- It's difficult to deal with PCP; we have many patients come without a referral. It's a financial hardship. It's always after the fact that we seek referral and many times we're denied.
 - Patients don't care; they don't care what it costs. They just want it when they want it.
 - If they can't get in to their provider, they go elsewhere; then the referral needs to be tracked.
 - Medicaid doesn't pay for ER visits for mental health. Why not? [Staff: Emergent services are, but not for routine visits.]
 - Why is the burden of proof on the provider, and not the patient?
 - I hate the paper system. Clients come in and say "Of course, I was referred." We have to have patients sign a paper saying they were or weren't. It's a huge burden.
 - Ultimately it should be the patients' responsibility, but apparently it's not.
 - Patients come to see us who have PP who are not staffed 5 or 7 days a week, so it's very difficult to reach them for referral information.
 - I've called many times on a tight time line I left name and number and get no response. This is a widespread problem. We have stacks of claims waiting.
 - We're not allowed to send patients or greatly discouraged from sending patients to out of state providers. We have to use in-state Medicaid facilities versus where we think they need to go for the best care.
 - When they are referred by IHS, when they are seen, and their PCP isn't aware of the referral ... It's the situation where IHS ISN'T their medical home
 - Referred-to doctors refer on, and a re-referral is not taking place by the PCP. So the PCP feels these things shouldn't be authorized, but if they aren't and you're not supposed to It could have been done in your office. The re-referral entity then isn't paid.

- c. **What do you suggest for the future? What other arrangements could better meet his objective?**
- Reimburse PCP for case management for complicated cases and kids with special health care needs.
 - Show clients what Medicaid pays out for them. Otherwise there is no check on the system. It tells the patients AND insures they were really seen.
 - Let patients know what the charges are versus what they paid. They would then realize the value of the service.
 - Rewards for people. People who try to use the system appropriately are often punished. There is not stick for abusing it; there are also a lot of monetary punishments for NOT providing services.
 - We harm ourselves; the client has no disincentive for abuse. Rewarding people for eye care and dental care makes sense. Maybe they could be incentivized with additional services. Patients don't currently care. They feel entitled, which ruins the whole system. Explain why they receive incentives such as well child visits. Rewards could be dental care, waive the co-pay, monthly prescription fee reduction program.

2. Assure adequate access to primary care

- a. **How is PASSPORT successful in meeting this objective? What do you appreciate about it? What currently works smoothly?**
- High immunization rate.
 - We're a referral office. They get the care they need when the patient follows the guidelines.
 - IHS has been a PCP all along.
 - We allow people to walk-in clinics.
- b. **What doesn't work as well as you need or want it to? What problems do you experience? What concerns do you have about this objective?**
- The patients need more education. They go to a walk-in clinic; we call the PCP who says "no." The patient doesn't know the procedure. They need more explanation – beyond letters. They take cards out of the envelope in front of us, but don't read the letter that accompanies it.
 - At IHS, even though Medicare / CMS educate, and it's our responsibility too. We do in-house education, sit and explain it to them. They don't fully understand the provider concept. We explain how specialists don't get paid. We also suggest they change their PCP.
 - It's terribly confusing. You need to come to IHS facility and followed their rules, and go to ANOTHER provider.
 - People have to have a medical screening exam. We do it, call their PCP, wait for a return call, and the patient may have already waited three hours. We treat them, get them out the door, and then aren't paid. The ER does not require referral, but the adjoining clinic does. People know how to play the system.
 - People expect that nurses and doctors are reachable, like they were in the 1960s.

They call every five minutes asking why their prescription hasn't been filled. The system assumes we have time during the day to see people; this isn't happening at all. We are encouraged to do things that aren't billable; phone calls are not billable.

- Emergency room crisis: People can't get into to see their PCPs.
- At most doctors' offices you get an automated phone system. If you call an ER, you get a real person.
- Why are they assigned to someone else other than IHS? Patient has no disincentive to not go to both.
- Pregnant women might go through all prenatal care at the Crow Reservation facilities, and then hop up to Billings for delivery, where they say "I have Medicaid."
- We try to see people ASAP but can't, so they instead go to walk-in clinics. It wrecks the medical home idea.
- Urgent care doesn't fit with the PCP model. PCPs are busy.

c. **What do you suggest for the future? What other arrangements could better meet this objective?**

- Let's do our own education.
- Joint authorizations for specialists' visits - referred and authorized by IHS.
- Regarding people who say "Oh, I have a PP?," send a list to doctors saying this is your person. Doctor can then send a little note of welcome and "hope to see you soon." Let the patient know that we know that we are their provider. Provide the patient a history form to fill out and bring in to the doctor.
- Look at walk-in clinic visits; allow same day care. EVMS and schools used to allow this for certain kinds of visits, such as for headaches.
- The Billings Clinic experienced a call "my son has been stung by a bee." The patient couldn't get into their PCP. How about no referral being needed between doctor and urgent care for situations such as broken arms? Integrated health care in the community, a version of what North Carolina does.
- Collaborative model, share information to avoid repeat of information. Share records. Then the PCP is aware of what care is being given, and how much people go outside the system.
- Do something about dentist availability.
- Make it so patients don't have to re-apply every month. If you really want us to be the medical home, don't cut them off. Make eligibility continuous or quarterly.
- For a baby and parent who both have strep throat, they need two appointments. Same day care makes sense. We have to go back and forth between records. We eat fees. Have on PP for the whole family. Collaboration with same day care makes sense here.

3. Encourage preventive care

- a. **How is PASSPORT successful in meeting this objective? What do you appreciate about it? What currently works smoothly?**
 - They are getting well baby care.
 - Healthier babies are born.
- b. **What doesn't work as well as you need or want it to? What problems do you experience? What concerns do you have about this objective?**
 - Are healthier babies being born? What does the data say?
 - We have people come every single day; they have a true medical home!
 - Patients won't listen or at least don't do what we tell them to.
 - There is no availability of dental care, especially for kids.
 - The amount of "no shows." That spot on our schedules could have been given to someone else.
 - Preventing an obese life style is hard when they are worried about where they are going to sleep that night. We can educate all we want, but they have other things to worry about. It's a downhill circle.
 - Does Medicaid pay for heart disease prevention or cardiac rehabilitation and pulmonary rehabilitation or heart failure programs or diabetes education program? [Staff: Not currently.]
- c. **What do you suggest for the future? What other arrangements could better meet this objective?**
 - Tie an incentive to making a preventive visit to the PCP. Encourage them to show up, be seen and provide their history.
 - Consider a program like car seat car stops by the police, where they reward those with car seats with shampoos and other incentives. Provide these for well visits, and well child visits. Ask sponsors to provide the incentives.
 - Institute coverage of physical therapy, membership at the Y, cardiac rehab, and pulmonary rehab.

4. Reduce and control health care costs

- a. **How is PASSPORT successful in meeting this objective? What do you appreciate about it? What currently works smoothly?**
 - It saves \$20 million; that's a lot of money.
- b. **What doesn't work as well as you need or want it to? What problems do you experience? What concerns do you have about this objective?**
 - There is an incredible amount of paper work for doctors to fill out.
 - PP requires an incredible amount of employee time to make phone calls.
 - We add to the paper work burden by needing forms filled out.
 - When we aren't getting paid, it's saving someone money.
 - For kids with special health care needs, there's no check on whether the kid needs the service. Every kid with Downs Syndrome gets physical therapy, but

there is no evidence that physical therapy helps. Suggestion: An incredible amount could be saved if a traveling van and staff monitored this. No one denies this service request.

- We're eating the costs.
- How much paper work and phone call time would be saved if ER visits didn't require a referral? (A PASSPORT referral is not needed for ER services).
- If a patient comes in from a doctor's office and is asked to be observation case, does it need authorization? They are a direct admit. [Staff: There are so many exceptions.]
- What percentage of admits are denied authorization? It could save time and paper work if they are always authorized.
- Suggestion: Manual claims. Anything we can do electronically, automate processing so we don't have to worry about paper claims. This would streamline things tremendously.
- Do physicians like all the paper work? What do they want to deal with?
- Most of the paper work I get is retro-active, and if I allow something, the whole system is a joke. If I don't authorize, someone doesn't get paid. ERs and clinics have a liability concern for turning someone away. Nurses ask for referrals from those likely to say yes, and avoid those that typically say no.
- I order oxygen or a nebulizer, and have to fill out a form after the fact, AND grinds up a whole lot of your day.
- Why does PP expect the submission to be quirky and not a normal standard thing, without whiting out numbers or electronically? Even getting it to you is quirky; the system won't take our claims. We can't talk to a certain person who can help us. [Staff: This can be helped.]

c. **What do you suggest for the future? What other arrangements could better meet this objective?**

- For getting referral for school based speech or physical therapy, drop the authorization. Keep the doctor informed. There is so much paper work with IEP anyway; it would save a minute of their 40 hour day.
- If you are going to keep exemptions, include allergy shots. You have to get PP authorization for EACH shot.
- New goals in the IEP require new authorization with the PCP.
- It all would work better if it were easier – when they need a referral and when they don't.
- Make it the same across the board. Our doctors (ear, nose and throat) are specialists, are called by the ER, and then our claims aren't paid. We need to streamline or make a solution so this is taken care of. Shouldn't they be paid? PCPs are called on Mondays. Streamline the link between weekend and after hours when they can't see their PCP and the patient needs to go to the ER.
- Improve customer service from the state staff on claims assistance to reduce denials – and frustration – which in turn costs money!

Create your own model – small work groups– proposals

Model A proposals

- Model Medicaid like insurance companies that have preferred providers where patient seeks care through a designated preferred provider organization.
Examples: BC Preferred and New West. Patient would be responsible if accessed care through a non-participating provider, hospital or clinic.
- Patient education at the time of qualification.
- Patient could receive Medicaid card at the time they attend the education meeting.
- Patient must share accountability.
- Patient should see and review EOB regarding actual costs.

Model B proposals

- 1. Would like to see ALL Native American patients living within a Reservation area (80 miles) be assigned to the local IHS hospital / clinic as their PASSPORT provider.
 - Our own physicians and doctors can then make referrals or standing orders for specialists, etc.
 - Would help prevent frequent flyers – drug seekers and doctor shopping.
- 2. Shift responsibility back to the patient to get referrals. Emergency care would be the exception. If child, parent would be responsible.
- 3. Would like to see push in preventive care rather than crisis care. Then work from here.

Model C proposals

- Patient managed health care. Money in pot or catastrophic insurance. Spend down.
- Medicaid Clinics – 24 hour. Only see Medicaid patients.
- If they choose PASSPORT, they must follow the rules. PASSPORT is the reward for following the rules.
- Dental clinics and traveling dental care, federally funded.
- Eliminate PASSPORT referrals.

Model D proposals

- Re-evaluate who is truly eligible for Medicaid.
- Centralization of records so providers have access to see what and to whom care was given.
- Determine biggest cost to determine what is avoidable, and where money can be saved.
- Have the case manager or social worker assigned to the recipient track usage quarterly and educate their clients.
- Positive incentives (to get off Medicaid, see PCP, don't frequent ER.)
- Educate welfare officers to educate their clients. More money into case management.
- Information embedded in card that would store when and where the patient was seen.

Model E proposals

- Incorporate PP (and all its connected clinics) with WIC.
- Have Patient Pay agreement.
- Why don't we have a plan for those who consume the most resources?
- Coupons for services, like 10 coupons (for well baby), excluding ER.
- Do away with PASSPORT approval. Contract care with Case Management, highest risk for losing money, for patients with serious illness or disease, and the greatest risk for high expenses.
- Address frustrations. Need a better system for PP approval:
 - Not able to contact a live person.
 - Not getting calls back for approval.
 - Employee follow-up. Many different people in accounts.
 - Staff doing education rather than MDCD program
- Electronic notification to case management. Manage care.
- Have MDCD put a representative in WIC rather than staff doing education.

Model F proposal

- Integrated health care: Okay to refer within clinic.
- Contracts with other groups, such as after hours and weekends.
- Parody of continuation of care. Specialist is not paid, but labs and x-rays that are order ARE!
- Simplify appeals. If PP doctor denies, we need additional avenues.
- Reduce payment for charges that don't have PP approval, but not totally deny! We treated in good faith.
- Better training (more frequent and localized). Training at each hospital □ video conferences and conference calls.
- Summits offered to all employees of clinics, etc. Also, include patients; make them responsible.
- Incentive or rewards for clinicians. Reimbursements for doctors and dentists.
- Adjusted claims to go electronic.
- If client can show proof of co-pay, etc. Reward by waiving co-pay or ? Cooperate in whatever.

Feedback and suggestions about Referrals

- Doctors provide services in good faith, and find out two months later the person has a PP, and drove right by their medical home to another provider. A lot of calls requesting authorization could have been done by the medical home.
- Half the patients don't tell us they have Medicare. Yet it is the patient's responsibility to say here's my PP and Medicaid card, but they don't tell us. MEPS can tell us but we find they were eligible last month, but aren't now. Then we're stuck. Do something differently with eligibility.
- Even with PP retro-eligibility, there's not way to call and find out. Eligibility doesn't show up.
- No quarterly number changes. It would make more paper work for doctors. If someone comes back three months later, you'll have to look for the old number. A big no vote!
- Nurses sometimes rattle off number without even hearing the whole request. Some physicians never give it; others always give it. Doctors say "Quit calling me," or "We're not open, here's our number."
- There's no correlation between denial and acceptance, and need for service. This is nickel and diming it. It can't be worth \$3.00.
- The service is done, I'm the PCP, and I wasn't reachable. Why not approve it? We don't change the patients' behavior.
- Educate the providers about prescriptions. Send us a mailing (and make us read it) about the cost of each prescription's total cost.
- Focus on outcomes and impacts. Focus on the things where we can make a difference in improved patient care. We're not doing this for the \$3 per patient. But I would if I could have better patient outcomes, and I'm rewarded with information on results, and reward patients. If I spend a half hour to 45 minutes, with a 91212 diabetes (patient education), I'd like to be rewarded for doing that - that is effective, make better patient outcomes, and keep them out of the hospital. I'm paid more for visiting them in the hospital! Teach us what has better outcomes and let us do it.
- Pay them more to do a better job - and the same with patients - see their PCP, quit smoking, etc.
- The new card has no information but an ID number; it's worthless. The old one was helpful in registering patients. Sometimes there's no way to verify if they are active or not. It should be like a regular insurance card; why is the Medicaid card so blank? The identification number of the card does you no good on the MEPS system. [You can bill, but not verify.] Test this.

What should always require a referral?

- Where the Program sees huge risk or expenses, or where you see abuses.
- What if the huge risks and expenses are with newborn procedures?
- Do it like commercial insurance companies require.
- Do continual utilization review and focus on the problem areas. Like walk-in clinics and people going to the ER three times each month.
- Regarding a six month billing limit, there was some support for it, and for other attendees it would be a hardship.

What should NOT require a referral?

- Request direct access for annual GYN exams. All other commercial payers allow this. Family planning services are covered but NOT annual exams. We are getting denials on these. [Staff: no referrals are needed for annual exams.]

- Eliminate the 30 day limit on tubal ligation and post partum. If the patient doesn't get it on time, unplanned pregnancies sometimes result.

Regarding MEPS and Team Care ...

- There is nothing in the box. I'm hearing you need to get a referral. Something needs to be in that box – name, phone number, on that page about Team Care. [MEPS is being re-designed and will be up in September.] No date, no information provided now. Can't tell us when people switch in PP.
- Pay for newborn circumcisions.

Feedback and ideas about improving education about the Program

With service providers

- I get four inches of mail daily, most of which I sort into the trash and non-trash. I trash Medicaid mail.
- Suggestion: Appear in my office once a year and tell me what's going on in Medicaid. I'm told my patients have case management, and they don't know who this is. This works for diabetes education. See all six providers in my office. There could be a little dialogue and we could ask questions.
- Staff: How do we get physicians to meet with us? In Colorado, doctors have to get points for doing things like this – such as to get a PP authorization status. Food doesn't always work, but holding their Medicaid PASSPORT status over their heads might work. Provide an incentive for me to show up and learn.
- Our business office manager arranges it and we show up; she makes it mandatory.
- Our doctors don't know the abbreviations that appear in the Claim Jumper – and it's repetitive.
- It would be helpful to meet with our nurses. They are key.
- Face-to-face works the best.
- It has to be held in non-productive time, which is hard. Patients are the priority.
- Show up with lunch for 45 minutes, and you will get a fair number to show up.
- A big dinner after work won't generate a lot of people, but at conventions might be worth trying.

With patients

- There's a big non-compliance issue. Why have requirements? Incentivize and fast track those who follow the appropriate protocols.
- Make it into a video game; young people are all about electronics.
- Face-to-face. Ninety percent of what we are doing is social. No one else is around to tell them they are sick. Call your social worker. What we do is cut back on face-to-face and cut back on social workers, who already have 3,000 clients. Insert someone else to help check up on them. [Staff: Focus on those who present a problem.]
- Has it ever been tried to require a client to pick up the cards at their PCP? Maybe this is perfect for IHS. Staggering cards might be a nightmare.
- Consider a drive-up window.
- Put that responsibility back in the county offices. We could ask for a waiver so this would not be required?

Individual participant worksheets

1. What do you most want the Program to consider from today's conversations?

Hospital or providers at a hospital:

- Under assuring adequate access to primary care notes: The problem with ER abuse (is that) clients know if they state they have an emergency so they need no referral to be seen, and they know they HAVE TO BE SEEN and evaluated no matter what the chief complaint. So, even if the complaint is not an emergency, a screening exam has to be done and the PCP needs to be notified about a referral or an appointment. This ties up staff and patient rooms for at least the 60 minutes time the PCP has to respond. (A PASSPORT referral is not needed for services performed in the ER. An ER claim will neither pay or deny based on a PASSPORT referral.) Bottom line: Staff is tied up, rooms are tied up, waiting times increase and other emergent / urgent patients wait. Team Care clients that show up at locations other than their PCP need a referral AT THAT TIME unless emergent. Anytime a Team Care client is seen outside their PCP, their PCP needs to be notified ASAP.
- Swipe cards to track the frequent flyers. Drug abuse is such a huge issue and patients go between many facilities looking for drugs. Can we get a system to track these patients and find a way to put this information out without violating HIPAA?
- In an IHS mind set, look at assignment of PP to the IHS clinics and hospitals, rather than a clinic in Great Falls, Billings, Hardin, etc. Also, keep in mind URBAN CLINICS UNDER IHS, such as Billings Urban, Helena Alliance, etc. to be assigned as PCP. My push is to keep MCD patients who are IHS / MCD eligible within IHS service units. Create and utilize an on-line referral system.
- Use of incentives for following preventive care programs.
- Education is good, but we need to do it in ways that people understand. If general reading level is 4th grade, do they understand what we're telling them? Do they have phone or computer access? The American culture is an entitled one; many of these issues are beyond just this population.
- No PASSPORT on all patients except certain groups. Grouping or contract the PCP with the clinics.
- How hard it is to get PASSPORT approval or facilities to return calls for approval. Money lost due to PASSPORT denials. Integrated health care between clinics and PASSPORTS. Managed care with case management.
- The amount of time between approvals. Integrated WIC and clinics and other hospitals, so there is no difference between them.
- Help us with problems. Learn more information. Give suggestions. Indian Health Service: They should be PP for all Native Americans.
- Eliminate the PASSPORT referrals on the small dollar work. In visits that just nickel and dime the provider and the provider suffers when they don't get paid.
- More education of patient liability / responsibility for the recipient. Make recipient more accountable for their responsibilities.

Billing office staff or office managers:

- Assign PASSPORT providers to the IHS hospital – the Native American patients instead of letting them choose would really help us. Then we could educate our own people – mailing the cards to us instead of the Medicaid patients. Or utilize an on-line referral system.
- Changes need to be made. Referral system has many problems and frustrating for staff. Medicaid may be saving money, but pharmacies lose money. Patients need to be more responsible.
- Do not require school-based services to get PASSPORT approval more than once a year. (IEPs are good for one year.) Do doctors feel authorization is necessary for school-based services when they will receive services regardless, because of “free education”? Schools will just not get reimbursed.
- Why do clients qualify for both IHS and Medicaid?
- We bill for school-based services and are required per Medicaid rules to obtain PCP sign off in order to bill for physical therapist, occupational therapy, and speech / language therapy in a school-based setting based on the goals set in the students Individual Education Plan (special education). There has been mention of PP numbers changing every three months. This could create a paperwork nightmare for all involved, including the PCP. Could we be exempt from having to use the PCP number to bill Medicaid, but still provide the PCP with a copy of the yearly IEP with updated goals for the therapies mentioned above?
- Eliminate the need of PASSPORT Provider referral for school-based services. Same entity referral approval – example: Billings Clinic PCPs referral good at all Billings Clinic offices, departments, etc.
- Patient being responsible for referral before visit, by contact with PCP.
- Your hospitals, providers, clinics, physicians, technicians, nurses, business office managers want to be part of the solution, and not contribute to the problem. Recognizing, of course, the small sample that actually bothered to show up.
- Patient education.
- Education before getting the card to use. Making it the patient responsibility to know how the PP system works.
- Medicaid card is worthless. Referral system is not working, and it was comforting to hear it is everyone experiencing the same thing.
- FQHC be exempt from the referral process – inpatient and outpatient.
- Determine where most dollars are spent and focus the managed care on where it will be most effective. Cut out requirement for authorization for referrals. Make patient more responsible to get referrals.
- Re-evaluate each person’s eligibility. We see patients driving late model SUVs who are in the clinic once a week and “cannot afford” their co-pay. They can afford a cell phone, etc.
- The referral process seems cumbersome and broken. Physicians write off a lot but the patient still receives services. Medicaid “clinic” for same day care situations – PP for referring to specialists.

PCPS

- Figure out how to handle patients referred by IHS to specialist, and from specialist to specialist, when we are the PCP, such as whether or not to authorize visits retroactively. If not authorized, it just decreases payment to the provider; it doesn't change patients' behavior.
- Incentives for better health care for clients and PCP. Have the ability to decrease cost by insuring that care is necessary. Review necessity of therapies. Let clients see the services and cost of their services.
- MORE CASE MANAGEMENT for problem clients. The new cards are a real problem; they are being passed around. Swipe card.

Others:

- Allow women direct access to OB/GYN physician for annual exam and care as provided in Montana State Statute 33-22-1904. See letter from Dr. McCracken (Montana Section Chair of ACOG).
- Increase communication between PCP and non-PCP to ensure appropriate care given.
- Doctor from Hardin stated (it) best: Payment should be made to facility / provider who rendered care. Coupon system: When client has used all "done" responsible to use wisely.

2. What do you find the most frustrating about the current approaches?

Hospital or providers at a hospital:

- The fact that the health care system and PCP have all the responsibility and the patient has none, healthcare systems and PCP spend lots of money "babysitting" these patients through the process. Patient abuse of the system: I had a patient tell me "Don't lose that card; with that I can get anything."
- I think the walk-in clinics SHOULD have referrals. Example: I had a patient come in and want her kids seen for colds X 24 hours. When I called their PCP, I was informed both children actually had appointments that day. I informed the patient of this; her response was "Yeah, I know, but I don't want to wait that long." This behavior is not appropriate; it takes away from the Provider and leaves them with "no show" time where they could see other patients and burdens the system.
- So many different rules.
- The differences and exceptions to all the rules. Some eligibility problems showing on MEPS. Patient abuse of the system or systems within clinics and PASSPORT/MCD. Monthly eligibility: Can we expand the eligibility to more than one month?
- I have very few frustrations with Medicaid Programs. It's getting them signed up for Medicaid and keeping them longer than one month.
- Emtala, etc. "we don't have a choice."
- The IHS / PASSPORT issues: It's far too complicated for providers, let alone the patients.
- Getting PASSPORTs.
- How hard it is to get PASSPORT approval or facilities to return calls for approval.

Money lost due to PASSPORT denials. Patient not accountable for going to primary care doctor. Facility is taking consequences by eating costs of visit because PP denies visit. Emtala: not able to make contact PP PRIOR to medical screening, then not able to make patient pay.

- The "repeat offenders." There are no consequences for these people who abuse the system. In return, there is no reward for the people who use it correctly. Also, the amount of "needed PASSPORTS" and the time frame in which the PCP relays the approval or denial needs some work! It should take less time and it MUST be a PCP priority!!!
- Too much time involved for SMALL payment.
 - Calling for all the walk-in PASSPORTs and not getting it and then having to follow-up, follow-up.
 - Patient lack of responsibility for anything.

Billing office staff or office managers:

- The referral system ... listening to every one else.
- It is time consuming, paperwork galore " and we feel the burden of responsibility, not Medicaid or the patient.
- PASSPORT Providers limit number of pre-authorization visits for specialist care.
- PCPs not signing off on a referral because they haven't seen patient (student). It is a team decision of school professionals in deciding a child needs therapy based on testing, observation, and professional opinion.
- The time it takes to get PASSPORT approval in order to bill.
- Difficulties with denied claims.
- Customer service at Medicaid is horrible. I want my claims to go through clear the first time, and not waste your time. Please provide me with someone to ask my questions to.
- Team Care: A better way of showing patients on MEPS. Clinics are having a hard time locating information. Why can't it be noted like PASSPORT?
- The unavailability of PP authorization in a timely manner. Some clinics (are) only open one day a week or the doctor is in only two or three times a month.
- The PCP denying PP authorization even though they are part of the same medical facility.
- Clients have no responsibility.
- That we as FQHC have to eat so many visits due to the way the referral process works.
- The time spent calling to get authorizations / denials from the PCP, and then the time spent waiting for answers.
- The plastic card. The "old" paper cards had all the information we needed. Online MEPS " super, when computers don't crash! We've had several occasions where both the computers and the phones are down " how do we verify?
- No "appeal" when the PP physician disappears. INTEGRATED health care.

PCPs:

- In our practice, some providers deny almost all retro-active authorizations; other doctors approval all. One doctor calls and gets specialist paid. Just depends which doctor is asked each day.

- Paper work. I was very upset about the tone of the meeting toward people on Medicaid.
- We are talking about our frustrations and not looking at specifics about financials or even more importantly, outcomes. The information never gets to the provider. We have too much to read. Someone needs to come around to offices for lunch with a little dog and pony show regularly.

Others:

- Women can access care from OB/GYN for [family planning] but it is VERY unclear exactly what that means! Can we perform exam (PAP smear, pelvic, and breast exam)?? Often that is denied, yet this should be done prior to providing contraception, etc.
- Inadequate communication.
- Not clear cut for providers other than the primary care provider, appears that client holds [all the cards;] should be more of a partnership.

3. What would make you a champion and supporter of PASSPORT, and truly advocate for it?

Hospital or providers at a hospital:

- To be more creative within you own clinic/office to help educate and promote education and control of health care costs. Education to our own population that we serve. Identify contact people at other offices to keep dialog on what we feel are problems and how we can form ideas to better help the people we serve, while promoting the PASSPORT Program. That all clinics follow the rules or eat the cost. We can't blame Medicaid because we know the rules but expect to be paid on [good faith.] Will be willing to be the project pilot for IHS to do education and receive cards, etc. Maybe something will work. Have a Summit in a central area for IHS and Tribal Councils only to discuss MCD and PASSPORT issues!
- ... develop in getting responses the PCPs. Let's manage the exceptions and not the rules!!
- Managed care [get rid of PP approval. Integrated health care between clinics.
- Rewards and consequences. Eliminate PP program for the people without a serious illness or disease. The people who are in bad health are more likely to be responsible enough to follow the rules.
- Get rid of PP number except for disability and extremely sick people.
- Be an advocate FOR the provider and their concerns.

Billing office staff or office managers:

- I do believe it is a good concept. I do believe, if possible, more accountability by the client.
- Patient education.
- Encourage my facility to call with problems and questions, and receive it well, instead of discouraging the feedback and making us feel like idiots for asking, and not knowing the answer in the first place.
- Patient education and responsibility.

- If patient really NEEDS care, I would wish that all after hours visits and weekend visits ... be covered without PP authorization.
- If PP had group providers □ to eliminate patients going from different facilities and PP denials.
- If the patients were to be more responsible for following the PASSPORT rules. If we can get a waiver for our facility not to have to get referrals.
- If it was really efficient and did not take a full time employee to administer and track.

PCPs:

- Positive reinforcement of wellness exams. Negative reinforcement for abuse of ER, drugs, etc. I just don't know any way to provide either positive or negative reinforcement. Educate physicians on Medicaid costs. If \$100 million is for pharmacy, if we used one less pill per patient or 20 pain pills instead of 30, it could be a significant savings. Prefer to eliminate referrals but track number of ER visits and have mandatory counseling / education for patients who are frequent fliers. Educate physicians on authorization of referrals / visits (such as when to authorize, when to deny) since there is no standard of care at this point. Positive reinforcement. Get major companies to donate debit cards for their products (toothpaste, shampoos, make up) for patients who get wellness exams, and don't use the ER, etc.
- Make the clients responsible for getting PCP referrals and co-pays. May them pay co-pays up front.
- A lot of unmarked \$20s. Yearly send someone to my office □ update us, get feedback, respond.
- More outcomes information: where are the problems, where are the successes, what can we change to improve?

Others:

- If women were allowed to access their OB/GYN provider for their ANNUAL exam. (Annual exams are allowed from an Ob/Gyn without a PASSPORT referral from the PCP). Other additional care, if needed, could be assessed via permission from the PASSPORT provider. This occurs with MOST commercial plans in Montana.
- Not sure at this time.
- Feel that in spite of flaws, I already am. As a member of society, need to help the less fortunate. Incentives for good PP clients. Scholarships, kids camps, adults □ health club.
- ER MD to specialist: Who is responsible for notifying PCP? Determine PASSPORT client calls, nurse hotline, state's facility, planning to go to, hotline calls in authorization to facility.

1. What were the **most** productive or helpful or interesting segments of today's meeting?
 - Brainstorming in groups. Listening to everyone's model (positive theories).
 - To hear the problems other clinics and hospitals are experiencing. The ability to verify questions that I had in regard to referrals, picking a PCP, etc.
 - To see the people with the same problems we have.
 - Learning the obstacles many providers, billers, etc. face.
 - Sharing information among all others in workshop. Listening to other ideas. A facilitator that was not associated with the Program. It was good to have physicians participate instead of just billing staff.
 - It all was.
 - Great and informative seminar.
 - Reviewing the four objectives.
 - Everyone is equally frustrated – which helps! Plus, reinforcement should work if we can come up with an acceptable reinforcer.
 - Learning how the PASSPORT system works.
 - Learning about PASSPORT in general.
 - Brainstorming and getting feedback from other facilities Getting feedback from MDCCD reps.
 - Brainstorming new ideas and models for a new way of doing things. Also, group debate was helpful and other clinic and people's viewpoint gave great insight.
 - Excellent! Great opportunity to share.
 - Brainstorming. Hearing other providers' problems. What other states have tried. Seeing someone write down each and every suggestion, problem and concern.
 - Lots of great suggestions. Possibility for improvements for providers. Possibility of not having to use PASSPORT provider number.
 - Referrals and eligibility discussion. Medicaid recipient has no responsibility. Providers have the burden.
 - It was interesting to see how many other facilities have this same frustrations and issues.
 - Different views of participants.
 - Being able to give input.
 - Hearing that other providers have the same issues as yours. Hearing the physician's side of the PASSPORT.
 - Addressing the four objectives. Providers appear to all have the same problems and solutions.
 - Hearing the ideas from others.
 - Perhaps more effort to get people to think outside the box.
 - Work group and question/answer session.
 - It was useful to hear that others are similarly frustrated!

2. What were the **least** productive or helpful or interesting segments of the today's meeting?
 - It seemed more doctor focused.
 - Negative comments.
 - There are no definite answers to our concerns.
 - Not sure. Found it all helpful.
 - ? Good discussion; all productive.
 - The slide presentation. It was just read to us and we were not given the slides on paper. It was just pointless and gave not as much information as the discussions did.
 - Please watch your poker faces. If you want us to be totally open about any and all suggestions, please convey sincerity in considering. And I'm not talking about the comments that were obviously a joke, and those want both ways.
 - Background information.
 - So much inter-discussion made it difficult to hear. Rephrasing the questions or statements from the front, addressing the group would be helpful.
 - Your description and map to where the meeting was taking place.
 - I thought going through each objective was a waste of time. It could have been done at one time.
 - Power point recitation.
 - Little outcomes discussion where actually are the problems.

3. Did you **accomplish** what you wanted to accomplish? If so, what subjects or issues or topics were they? What, if anything, did you get out of the meeting?
 - Yes. I learned today and have a greater understanding of the PASSPORT program.
 - Yes. Mention of eliminating need for PP sign-off for school-based therapy sessions.
 - Overall it was a good session, knowing that Medicaid is willing to listen and perhaps change.
 - Yes.
 - Somewhat access to care and medical home.
 - Yes I vented!
 - The information didn't apply to a specialty office. Please don't invite such offices at the same time as hospitals and clinics. We have completely different issues.
 - It was interesting to hear about all the problems people have with the referral process.
 - Yes.
 - Learned more about MDCD. Good opportunity for discussion on processes.
 - I learned more about MDCD than I ever wanted to know! Yes, everything was accomplished!
 - We're not alone! Similar problems elsewhere.
 - Very informative.
 - That PASSPORT is not really working for anybody but the patients.
 - Yes, great information.
 - Having people really listen to provider concerns and be willing to address them.
 - The meeting accomplished great communication and gave me hope that changes are forthcoming as we all agree improvements can be made.
 - I had no preconceived ideas.

- Yes. Spoke opinion regarding current plastic card. Referral process explanation was good.
- Yes, nice division of topics and pace of meeting.

4.a. What **changes and improvements** do you suggest for future meetings like this one?

- IHS Summit.
- If there was a Summit for IHS clinics and hospitals, that would be helpful.
- Shorter length.
- Sometimes repeat of some of the questions. Try to have less side conversations.
- IHS Summit.
- It think it worked well.
- Make the meeting a half (and full lunch) day sessions in the morning and afternoon.
Example: Morning would be for new people who have never been and afternoon would be for updates, ideas, questions and answers, etc.
- It would be helpful to have more meetings.
- For them to be more often. We need to hear from the "heads" and share all of our questions with them.
- Have the Medicaid officers sit separately so we know who they are. Maybe actually face us.
- Keep asking and responding to suggestions. Difficult to hear speakers. Medicaid people talking to each other in front of you. Some speakers spoke softly when answering questions.
- Expand on ideas, if any have been implemented.
- Leave out some of the background information, and get to the issues.
- More heat in the meeting room.
- PLEASE. The time used about people on Medicaid was very worrisome. Needed more providers at the meeting.
- Would like to see several algorithms of referral process.
- Shorter rows or mid-row breaks.

4.b. What would you like to have left **exactly as it was** at this meeting? Keep these characteristics:

- The conference room and location; it was nice.
- PASSPORT approval to keep the continuity of care.
- The morning session was very good.
- Facilitation. Open forum.
- Facilitator to keep it moving.
- Facilitator was great! Group sessions were very enjoyable.
- Thanks, it was great.
- All.
- Open discussion / forum / debate.
- The discussion and group debates.
- Introduction. Nice to be reminded what a wide range of health care provision Medicaid touches.

- Food was great.
 - Love the open discussion.
 - The meeting itself was very well done.
 - Open format.
 - Interaction between ALL entities. GOOD to have the diverse group.
 - Huh?
 - Lots of opportunity for discussion.
5. Any feedback about the materials you received prior to the Summit?
- Mailed to us earlier.
 - Good reading material □ helps to look at the whole overall picture, not just my concerns.
 - I didn't get any. I was called and asked to come, but didn't even know where it was.
 - Very informative.
 - Good information.
 - They were great.
 - Okay.
 - Very organized.
 - We did not need bags or special binders □ not a good use of resources.
 - Good. Plan to share with my directors and peers.
6. Any other feedback, suggestions or ideas?
- Would like to know all the PCPs in my county and also be able to see costs.
 - I think we received too much paperwork. This was a meeting based solely on opinions and ideas and discussion. Why waste trees?
 - Beki and Mary were very informative.
 - Very good facilitator!